TREATMENT AGREEMENT (2 PARTY)

Initial after each line after you have read and understand what is written.

Pharmacist Responsibilities

As your Community Pharmacy Team, we will:

Respect and not judge you and listen to you with undivided attention _____

Focus on your safety and the safety of those around you _____

Communicate with your prescriber other healthcare providers involved when necessary, including when a medication dose has been missed, you appear impaired before you get your dose and if we see you vomit shortly after you take your medication _____

Not speak to anyone outside your healthcare team about your care _____

Review information about your medication with you and answer questions you have _____

Check your identification to be sure your medicine is given to the correct person _____

Make sure you understand how to take all your medications properly and monitor for and help you manage side effects of your medication _____

Provide your medication as it has been prescribed and only to you _____

Watch your medication being taken when required and have a conversation with you afterward. Depending on the situation, we may have you drink water either before or after you take the dose _____

Offer a private area to supervise you taking your medication _____

Provide your take home doses in a child proof bottle that is sealed as appropriate and remind you to store them in a locked box in the refrigerator _____

Accept and properly dispose of your take home dose bottles _____

Help coordinate your urine testing and take home dose inspection _____

Review your medications for possible interactions _____

Make best efforts to have your medication available in the pharmacy when you need it _____

Keep timely and accurate records about your care in the pharmacy _____

Help arrange for medication to be available elsewhere if there are days our pharmacy is closed _____

Help coordinate care for you when you plan to travel out of the area _____

When it is no longer possible to continue to provide you medication at our pharmacy, make best efforts to continue your treatment until other arrangements can be made or if your care can’t be transferred to another pharmacy, to provide medication while your dose is slowly and comfortably decreased then stopped _____

Follow all federal and provincial laws, pharmacy standards and guidelines _____
Patient Responsibilities

As the person receiving this treatment I will:

Treat everyone involved with respect and not judge myself or others taking this treatment _____

Follow all federal and provincial laws _____

Listen to you with undivided attention and share information with the clinic and pharmacy staff _____

Focus on my safety and the safety of those around me _____

Show up at the pharmacy or clinic at the agreed upon times for all my clinic appointments, urine tests, take home dose inspections and doses to be given at my pharmacy and not arrive before the pharmacy opens _____

Notify my clinic and my pharmacy as soon as possible if I am not going to be able to make it in when I am supposed to _____

Understand that the medication can only be provided when I have a valid prescription and make sure that I have a new prescription before my current one runs out _____

Show my identification when it is requested _____

Agree that my pharmacist will watch me take my medication and confirm that I have taken it, after which I will return the empty container _____

Lock and safely secure the doses I take home and accept that lost or stolen doses cannot be replaced _____

Provide supervised urine samples when the clinic requests them from me within 48 hours of being notified by my pharmacy or clinic that I am required to do this _____

Agree that my pharmacist and my provider will decide when it is safe for me to take doses home _____

Not give my take home doses to other people and return empty take home dose bottles to the pharmacy when asked _____

Pay for my medication before it is given and confirm that I have been given the medication by signing the pharmacy log book _____

Take my medication only as I am instructed to take it, ask questions if anything is unclear to me, including asking my pharmacist before I take any over-the-counter medication _____

Understand that for methadone, all doses must be prepared in Tang or other crystalline juice _____

Understand that a missed day means a missed dose, which will not be made up _____

Respect the pharmacy’s neighbourhood and ensure that all packaging materials and litter are disposed of in the garbage containers provided _____

Notify all other healthcare workers treating me for other health issues that I am taking this treatment and understand that my doctor, pharmacist, nurse and other providers involved in my care may need to communicate with each other concerning some aspects of my care _____

Tell my clinic and my pharmacy when I have been given a new prescription from a different health care provider as soon as I am given it _____

Understand that it is best that the time between my doses be a minimum of 15 hours _____
Bring extra bottles in to the pharmacy when asked _____

Use only one pharmacy and notify my clinic and my pharmacy right away when I need to move to a new pharmacy _____

Let my provider and my pharmacist know about any side effects I get from my medication _____

Understand that any doses vomited or any take home doses I lose will not be replaced without a written prescription from the prescribing physician or nurse practitioner _____

Accept that for my safety, any drug abuse must be reported to my doctor or nurse practitioner _____

Not consume alcohol or take other sedating medication and accept that that I may not be given my medication if I am under the influence of other drugs _____

Let my clinic and my pharmacy know if I am pregnant or planning to become pregnant _____

Other:

________________________________________________________________________________________________________________

________________________________________________________________________________________________________________

Signatures: ___________________________ Provider Date: ___________________________

_________________________________________ Pharmacist Date: ___________________________

_________________________________________ Patient Date: ___________________________